

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-037605

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 3005 Registrar's No. 199

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/596071
20070

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

BY AFFIDAVIT OF

FILLED OCT 30 1962

1. PLACE OF DEATH a. COUNTY BATES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY BATES	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN BUTLER		c. CITY OR TOWN ADRIAN Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BATES CO. MEMORIAL HOSP.		d. STREET ADDRESS (If outside, give location) Hi-Way 71 Residence on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ETTA Middle M. Last WINTERS		4. DATE OF DEATH Month October Day 17 , Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-17-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	11. BIRTHPLACE (City and state or country) WISCONSIN
13a. FATHER'S NAME WILLIAM HENRY BEAN		13b. MOTHER'S MAIDEN NAME MATILDA LETTEER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. INFORMANT Mrs. Bonnie Myers, Adrian, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO (b) Arteriosclerotic heart DUE TO (c) dissecting aortic regurgitation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Post-op. hip healing.		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> None	
20c. TIME OF INJURY Hour None a.m. p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) None	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None	
21. I attended the deceased from 8/4/62 to 10/17/62 and last saw her alive on 10/17/62		22a. SIGNATURE Douglas O. Howard MD Degree or title	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		23b. DATE 10-20-62	
23c. NAME OF CEMETERY OR CREMATORY MT. WASHINGTON CEMETERY		23d. LOCATION (City, town, or county) (State) INDEPENDENCE, MO.	
24. FUNERAL DIRECTOR GEO. C. CARSON & SONS, INDEPENDENCE, MO.		25. DATE RECD. BY LOCAL REG. 10-23-62	
26. REGISTRAR'S SIGNATURE Norma Jean Wilson		22c. DATE SIGNED 10-23-62	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John L Underwood

Licensed Embalmer No.

3585

P. O. Address

Butler MD

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.